DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/19/12

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445479	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GRAY	791 OLD GRAY STATION ROAD GRAY, TN 37615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to maintain the privacy of the medical record for one (#24) of twenty-four residents reviewed.	F 164	1. What corrective actions will be taken to correct this alleged deficient practice? a) Resident #24 medication administration record was immediately covered on 1/4/12 by licensed practical nurse #3. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a) All residents have the potential to be affected by not ensuring privacy of records. b) Unit managers completed a 100% observation on 1/4/12 of resident medication administration record privacy during medication administration. No further privacy concerns were noted. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) Licensed practical nurse # 3 was re-educated on proper procedure for covering medication administration records during medication administration on 1/4/12 by the assistant director of nursing. b) 100% of the licensed associates were re-educated on the proper procedure for covering medication administration records during medication administration beginning on 1/4/12 through 1/27/12 by the staff development coordinator. c) Unit managers complete daily medication administration records privacy compliance audits for four weeks, weekly for two months. d) The DON will audit the unit managers daily review of the medication administration records privacy compliance audits daily for four weeks and weekly for two months.	02/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lenora C Solomon, MA, Executive Director — 1/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The findings included: Observation on January 4, 2012, at 8:41 a.m., revealed Licensed Practical Nurse (LPN) #3 administering medications to resident #24, in the resident's room. Continued observation revealed the Medication Administration Record (MAR), for resident #24 was located on top of the medication cart, in the hallway, uncovered and visible. Review of the facility's policy Safeguarding Protected Health Information revealed "...Close MAR and Treatment notebooks when unattended in order to limit unauthorized access. A privacy cover sheet may also be used to cover the MARs..." Interview on January 4, 2012, at 8:58 a.m., with LPN #3, in the hallway, confirmed the MARs are to be covered when not in use.	F 164	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The director of nursing and/or the assistant director of nursing will report the results of the medication administration records privacy compliance audits to the performance improvement committee for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	02/17/12
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide an environment free of odors for one of four Units observed. The findings included:	F 252	1. What corrective actions will be taken to correct this alleged deficient practice? a) On 1/4/12 the Wheelchair cushion in resident room on 300 hall was identified as the source of the odor by the environmental services director. Cushion was cleaned immediately. No further odor noted. 2. Identify residents that have the potential to be affected by the alleged deficient practice a) Residents in the facility have the potential to be affected. b)The environmental services director completed a 100% observation on 1/4/12 of residents' rooms, bathrooms, and wheelchair cushions. No other odors were noted.	

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F 252	Continued From page 2 Observation on January 3, 2012, at 10:10 a.m., on the 300 Unit, revealed a strong urine odor. Observation on January 3, 2012, at 4:00 p.m., on the 300 Unit, revealed a strong urine odor. Observation on January 4, 2012, at 8:15 a.m., on the 300 Unit, revealed a strong urine odor. Observation and interview with the Corporate Nurse on January 4, 2012, at 2:25 p.m., on the 300 Unit, confirmed a urine odor present on the Unit January 3, and 4, 2012.	F 252	3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) The environmental services department was re-educated on proper cleaning procedures of resident wheelchair cushions on 1/4/12 by the environmental services director. b) Quality rounds are completed weekly by the nursing home administrator and the environmental services director to detect any odors in the facility. c) The environmental services director will make monthly checks of residents' rooms for three months or until 100% compliance is achieved 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The environmental services director will report the results of the odor audits and room checks to the performance improvement committee for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to follow a physician's order, and monitor and document results/response to as-needed medication for one resident (#8) of twenty-four residents reviewed. The findings included: Resident #8 was admitted to the facility with diagnoses including Orthopedic After-Care, Diabetes Mellitus Type II, Chronic Kidney Disease, Hypertension, Hypothyroidism and Depressive Disorder. Medical record review of the Physician's Recap Orders dated November 2011 and December			

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F 281	Continued From page 3 2011, revealed" ...Clonidine (high blood pressure medication) 0.1 mg (milligram) by mouth once daily PRN (as needed) for b/p (blood pressure) > (over) 170 systolic (top number) ..." Medical record review of resident's "Vital Sign & Weight Flow Sheets" dated November 2011, revealed the resident's blood pressure was recorded twice daily on most days. The systolic pressure was over 170 on November 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 2011. Medication review of the Medication Administration Record (MAR) dated November 2011, revealed clonidine 0.1mg was not given on November 1, 2011, for a blood pressure of 184/88; November 2, 2011, for a blood pressure of 184/86; November 3, 2011, for a blood pressure of 177/88; November 5, 2011, for a blood pressure of 177/82; November 6, 2011, for a blood pressure of 185/80; November 7, 2011, for a blood pressure of 188/82; November 9, 2011, for a blood pressure of 182/79; November10, 2011, for a blood pressure of 183/83; November 11, 2011, for a blood pressure of178/81; November 14, 2011, for a blood pressure of 202/91; November 17, 2011, for a blood pressure of 172/85; November 18, 2011, for a blood pressure of 184/83; November 19, 2011, for a blood pressure of 178/92; November 20, 2011, for a blood pressure of 191/92; November 21, 2011 for a blood pressure of 189/85; November 23, 2011, for a blood pressure of 184/81; November 28, 2011, for a blood pressure of 172/78; November 29, 2011, for a blood pressure of 173/72. No post medication follow-up blood pressures were documented on	F 281	1. What corrective actions will be taken to correct this alleged deficient practice? a) On 1/5/12 medical doctor was notified of missing doses of Clonidine for resident #8. At this time, the medical doctor reviewed resident #8 medications and appropriate changes were made and orders were written. Resident #8 as needed Clonidine was discharged. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a) Residents in the facility with orders for as needed Clonidine have the potential to be affected. b) On 1/5/12, the medical doctor reviewed 100% of the residents with orders for as needed Clonidine. No other residents were affected. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) Nursing staff were re-educated beginning on 1/4/12 through 1/27/12 by the staff development coordinator on the five rights of medication administration. b) Unit managers will audit medication records daily to assure medications have been given timely for four weeks, and weekly for two months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The director of nursing and/or the assistant director of nursing will report the results of the medication administration record audits to the performance improvement committee for three months.	02/17/12

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F 281	Continued From page 4 the November 2011 MAR. Further medical record review of the Vital Signs and Weight Flow Sheets dated December 2011 revealed the resident's systolic blood pressure was over 170 on December 1, 2, 4, 5, 7, 8, 9, 14, 15, 16, 23, 25, 26, 29, 31, 2011. Medical record review of the MAR dated December 2011, revealed clonidine 0.1mg, was not given December 2, 2011, for a blood pressure of 196/92 or 196/90; December 4, 2011, for a blood pressure of 179/91; December 7, 2011, for blood pressures of 204/88 or187/83; December 8, 2011, for a blood pressure of 190/87; December 9, 2011, for a blood pressure of 190/88. Interview with the DON (Director of Nursing) January 5, 2012, at 12:10 p.m., at the Unit 2 Nurses' Desk, confirmed the medication was not given as ordered and when given, results/response were not consistently documented. Interview with the resident's physician on January 5, 2012, at 1:00 p.m., in the hall outside the conference room, confirmed the resident's blood pressure remained unstable and would require additional medication adjustment.	F 281	b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. What corrective actions will be taken to correct this alleged deficient practice? a) Resident #14 tab alarm was immediately applied on 1/5/12 by Staff Development Coordinator. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a) Residents is the facility with physician orders for safety devices have the potential to be affected.	02/17/12

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one (#14) of twenty-four residents reviewed. The findings included: Resident #14 was admitted to the facility on July 2, 2010, with diagnoses including Senile Dementia, Vertigo, Syncope, Osteoporosis, and Hypothyroidism. Medical record review of the Minimum Data Set (MDS) dated November 20, 2011, revealed the resident required extensive assistance with transfers and ambulation. Medical record review of a Fall Risk Assessment dated November 28, 2011, revealed the resident was at risk for falls. Medical record review of the December 2011, physician's recapitulation orders revealed the resident was to have a tabs alarm when seated in a wheelchair. Medical record review of the Care Plan reviewed on November 28, 2011, revealed "...Risk for falls R/T (related to) h/o (history of) syncope, dizziness, impaired balance, unsteady gait...tab alarm to wheelchair..." Observation on January 5, 2012, at 11:59 a.m., revealed the resident seated in a wheelchair, in	F 323	b) Unit managers completed a 100% observation on 1/5/12 of residents who have orders for safety devices. The observation revealed 100% compliance with the safety device application. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) 100% of the nursing staff were trained between 1/5/12 and 1/27/12 by the staff development coordinator on recapitulation orders and the importance of the verification of each order from month to month. b) Unit managers complete daily safety device audits for 4 weeks and weekly for two months. Director of Nursing reviews audit to ensure staff compliance with safety device application. c) The Director of Nursing will audit the unit managers daily review of safety device application daily for 4 weeks and weekly for two months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The director of nursing and/or the assistant director of nursing will report the results of the safety device compliance audit to the performance improvement committee for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	

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F 323	Continued From page 6 the dining room, and a tabs alarm was not applied to the resident or to the resident's wheelchair. Observation and interview on January 5, 2012, at 12:05 p.m., with the Staff Development Coordinator, revealed the resident seated in a wheelchair, in the dining room, and confirmed the tabs alarm was not applied to the resident or to the resident's wheelchair.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,	F 425	1. What corrective actions will be taken to correct this alleged deficient practice? a) On 1/5/12 the medical doctor was informed of resident #13 missed doses of Actonel. The physician reviewed the medications of Resident #13 on 1/5/12 and the formulary interchange was used for Actonel. The physician discharged the Actonel for resident #13 at this time. Resident #13 is currently taking calcium. b) On 1/5/12 the medical doctor was informed of resident #1 missed doses of Actonel. The physician reviewed the medications of Resident #1 on 1/5/12 and the formulary interchange was used for Actonel. The physician discharged the Actonel for resident #1 at this time. Resident #1 is currently taking calcium. c) On 1/5/12 the medical doctor was informed of resident #18 missed doses of Oxybutynin. The physician reviewed the medications of Resident #18 on 1/5/12. The physician discharged the Oxybutynin for resident #18 at this time. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a) Residents is the facility with physician orders for Actonel and Oxybutynin have the potential to be affected.	02/17/12

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F 425	Continued From page 7 and interview, the facility failed to provide timely pharmacy services for three (#13, #1, #18) of twenty-four residents reviewed. The findings included: Resident #13 was admitted to the facility on September 4, 2008, with diagnoses including Osteoporosis, Fractured Ankle, and Pneumonia. Medical record review of a physician's order dated November 9, 2011, revealed the resident was to receive Actonel (medication for Osteoporosis) 35 mg (milligrams) weekly, beginning on November 12, 2011. Medical record review of the November 2011, Medication Administration Record (MAR), revealed the Actonel was circled (indicating the medication was not administered) on November 12, 19, and 26, 2011. Medical record review of the reverse side of the November 2011, MAR revealed on November 12, 2011, Licensed Practical Nurse (LPN) #2 documented "Actonel 35 mg not in." Telephone interview on January 3, 2012, at 7:30 p.m., with LPN #2 revealed LPN #2 was responsible for the administration of the Actonel 35 mg on November 12, 19, and 26, 2011. Continued interview confirmed the Actonel was not administered on November 12, 19, and 26, 2011, due to being unavailable from the pharmacy. Resident #1 was re-admitted to the facility on August 27, 2011, with diagnoses including End	F 425	b) Unit managers completed a 100% observation on 1/5/12 of the medication administration records to ensure medications had not been missed. No other residents were affected. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) Licensed practical nurse #2 and registered nurse #1 received one-on-one re-education from the assistant director of nursing on 1/4/12 on medication administration including contacting the pharmacy and supervisor to ensure that medications are obtained in a timely manner and that medications are not missed. b) Nursing staff were re-educated beginning on 1/4/12 through 1/27/12 by the staff development coordinator on the medication administration which inclues the process of medication when unavailable. c) Unit managers will complete daily medication administration record compliance recordaudits for four weeks, and weekly for two months. d) The director of nursing will audit the unit managers daily review of medication administration compliance audits daily for four weeks, and monthly for two months. 4.	

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F 425	Continued From page 8 Stage Renal Disease with hemodialysis, Multiple Sclerosis, Hypertension, CerebroVascular Accident with Left side hemiparesis and Osteoporosis. Medical record review of a physicians' order dated October 17, 2011, revealed Actonel (used to treat Osteoporosis) 35mg (milligrams) one tablet by mouth every week. Medical record review of a Medication Administration Record (MAR) dated November 2011, revealed the resident did not receive Actonel on November 9, 12 and 19, 2011, because it was not available from the Pharmacy. Telephone interview with Registered Nurse #1 (responsible for the administration of the Actonel on November 9 and 12, 2011) on January 4, 2012, at 10:11 a.m., confirmed the medication was not administered because it had not been received from the Pharmacy. Resident #18 was admitted to the facility on June 6, 2011, with diagnoses including Hypertonicity of Bladder, and Urinary Retention. Medical record review of physician's orders dated November and December 2011, revealed Oxybutynin (antispasmodic) 5mg (milligram) twice daily. Medical record review of the Medication Record dated November 2011, revealed the resident did not receive Oxybutynin 5mg on November 16, and 17, 2011, at 8:00 p.m.	F 425	How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The director of nursing and/or the assistant director of nursing will report the results of the medication administration record compliance audits to the performance improvement committee for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	

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F 425	Continued From page 9 Medical record review of the Medication Record dated December 2011, revealed the resident did not receive Oxybutynin 5mg on December 2, and 24, 2011, at 8:00 p.m. Further medical record review revealed "...med not restocked from pharmacy..." Telephone interview on January 5, 2012, at 6:45 a.m., with Registered Nurse #1, revealed RN #1 was responsible for the administration of the Oxybutynin 5mg on November 16, and 17, 2011, and December 2, and 24, 2011. Continued interview confirmed the medication was not administered because it had not been received from the pharmacy.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the consultant pharmacist failed to identify a medication not available from the pharmacy for one resident (#18) of twenty-four residents reviewed.	F 428	1. What corrective actions will be taken to correct this alleged deficient practice?. a) On 1/5/12 the medical doctor was informed of resident #18 missed doses of Oxybutynin. The physician reviewed the medications of Resident #18 on 1/5/12. The physician discharged the Oxybutynin for resident #18 at this time b) On 1/17/12, the pharmacy consultant was re-educated regarding appropriate review of medication administration records and communication to the facility administrator and director of nursing on monthly visits by the pharmacy consultant coordinator. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a) Residents in the facility that receive pharmacy services from the facility pharmacy have the potential affected.	02/17/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445479	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GRAY	791 OLD GRAY STATION ROAD GRAY, TN 37615

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F 428	Continued From page 10 The findings included: Resident #18 was admitted to the facility on June 6, 2011, with diagnoses including Hypertonicity of Bladder, and Urinary Retention. Medical record review of physician's orders dated November and December 2011, revealed Oxybutynin (antispasmodic) 5mg (milligram) twice daily. Medical record review of the Medication Record dated November 2011, revealed the resident did not receive Oxybutynin 5mg on November 11, 12, 16, and 17, 2011, at 8:00 p.m. Further medical record review revealed "...reason...out..." Medical record review of the Medication Record dated December 2011, revealed the resident did not receive Oxybutynin 5mg on December 2, 22, and 28, 2011, at 8:00 p.m. Further medical record review revealed "...reason...med not restocked from pharmacy..." Medical record review of the Chronological Drug Review dated November 22, and December 29, 2011, revealed "...it is my professional judgment...no irregularities...available at time of review..." Telephone interview on January 5, 2012, at 10:12 a.m., with the Consultant Pharmacist, confirmed when a monthly medication review was completed, the pharmacy records and medication records were part of the review. Continued interview confirmed the Consultant Pharmacist completed a medication review on November 22,	F 428	b) Unit managers completed a 100% observation on 1/5/12 of the medication administration records to ensure medications had not been missed. No other residents were affected. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a) The consultant pharmacist will coordinate with the facility, on monthly visits, to review medication administration records and audit for medications that have not been given and that have been unobtainable from the facility pharmacy. b) During monthly visits, the consultant pharmacist will notify the director of nursing and/or the nursing home administrator of any irregularities noted. c) The consultant pharmacist will provide a monthly summary of observations and findings from the monthly review of medication administration records to promote residents safety in the facility. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a) The consultant pharmacist will report the results of the monthly medication administration record review to the performance improvement committee for three months. b) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	

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F 428	Continued From page 11 and December 29, 2011, and failed to identify the medication had not been available from the pharmacy.	F 428		
F 492 SS=F	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow state regulatory compliance with 1200-8-16-.02 (8) Requirements for Civil Rights by displaying a Civil Rights notice in a prominate place in the facility. The findings included: Observation on January 5,2012 at 10:00 a.m. in the facility's front entrance revealed no posting of TitleV1/Section 504 Civil Rights Requirements. Interview with the Nursing Home Administrator on January 5, 2012 at 10;25 a.m. in the front lobby confirmed the facility failed to post the notice for Civil Rights.	F 492	1.What corrective actions will be taken to correct this alleged deficient practice?. a)On 1/5/12 the nursing home administrator immediately posted the civil rights notice in the front lobby of the facility. 2. Identify residents that have the potential to be affected by the alleged deficient practice. a)\ Residents in the facility have the potential to be affected. b)The nursing home administrator completed a 100% review of required federal, state, and local postings to ensure compliance on 1/5/12. No further posting concerns were found. 3.What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? a)The 504 coordinator was educated on 1/5/12 on the required federal , state, and local postings by the nursing home administrator. b)The business office manager and the receptionist will complete daily posting requirement audits for four weeks, weekly for two months. The nursing home administrator reviews the audits to ensure associate compliance with required postings. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place? a)The nursing home administrator and/or business office manager will report results of the required postings audit to the performance improvement committee for three months. b)The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.	02/17/12